



CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons living in a Family Foster Home [K.A.R. 30-47-819] must have a health assessment.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

Name of the facility (exactly as stated on the license) _____ License # _____

Street Address _____ City _____ Zip Code _____ County _____

Check type of child care facility:

- | | | |
|--|--|--|
| <input type="checkbox"/> Attendant Care Facility | <input type="checkbox"/> Group Boarding Home | <input type="checkbox"/> Secure Residential Treatment Facility |
| <input type="checkbox"/> Detention Center | <input type="checkbox"/> Staff Secure Facility | <input type="checkbox"/> Secure Care Center |
| <input type="checkbox"/> Family Foster Home | <input type="checkbox"/> Residential Center | <input type="checkbox"/> Juvenile Crisis Intervention Center |

Name of Foster Parent/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.

- | | | |
|---|--------------------------|--------------------------|
| | <u>Yes</u> | <u>No</u> |
| 1. Do you see a physician regularly for any health condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking any medication regularly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any surgery in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any handicapping conditions which might interfere with the care of children? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any chronic illness conditions such as: | | |

- | | | | | | | | | |
|---------------------|--------------------------|--------------------------|----------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|
| | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

If Other, Describe: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. I do not find evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

Signature of Licensed Physician or Nurse trained to perform health assessments. _____ Date (MM/DD/YYYY) _____

2. I found evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

Signature of Licensed Physician or Nurse trained to perform health assessments. _____ Date (MM/DD/YYYY) _____

Record results of TB test or attach results to this form.

Negative tuberculin test or negative chest x-ray on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____ Date (MM/DD/YYYY) _____
Licensed Physician/Nurse Signature or Health Department